EHR Subcommittee 2 Meeting Minutes

Department of Medical Assistance Services (DMAS)
600 East Broad Street
Richmond, VA 23219
13th floor Policy and Budget Conference Room
August 29, 2005 (2PM)

Attendees:
Members:
Greg Walton
Kippy Cassell
John Dreyzehner
Aneesh Chopra
Guest Speakers:
Anton J. Kuzel, MD, M.H.P.E., Chairman of the Department of Family Medicine VCU
Hughes Melton, MD C-Health
James A. Lapsley – CEO, Loudoun Medical Group
Grace Hall – Director of Marketing Loudoun Medical Group
Staff:
Dave Austin
John Kenyon
Liza Steele

Review of 8/8 Teleconference Minutes (2PM)

- The August 8, 2005 Meeting minutes were approved as written.
- Dave recapped issue about potential conflicts of interest (for subcommittee #2 members) that came up in the 8/8 meeting. The conclusion of Executive Committee members of the Task Force is that there are no conflicts of interest for subcommittee members, because the subcommittees are not the final decision-makers. At this stage the subcommittees are just making recommendations. The final decision process to implement pilots and develop contracts will likely be done through a competitive bidding process. This means that subcommittee members who have affiliations with organizations can make recommendations without their affiliation with those organizations being a conflict of interest issue.
- Staff discussed the issue of the paid claims rate for DMAS that was raised at theAugust 8 teleconference. Staff agreed to find out the First Pass claim payment rate for the Medicaid Emergency Room claims.

Case Studies in the Development of EHR in Medical Practices

VCU Experience
Dr. Anton "Tony" J. Kuzel, MD, M.H.P.E. – Chairman of the Department of Family Medicine VCU

Experience with 3 residency programs adopting EHR. First was Riverside (5 or 6 years ago) chose Logician system; 2 years ago Shenandoah Valley program chose A4 system; Fairfax Residency as of April 2005 went live with All Scripts. Each program saw the potential for improved patient safety with medications, possible reduction of overall healthcare expenditures, and reduction of duplicative tests. All practices saw reduction of revenue for the first 3 months or so. One saw a reduction of about 15%. He said 20% reduction is typical for the first month, and then more like 10% for the next two.

Dr. Kuzel did some research on ROI and found a net ROI of $80,000 per practitioner over 5 years. That was in the form of reduced expenditures on lab and X-rays and medications. The practices that experienced this were part of a network and were in Boston.

The issue of being part of a network is key. Individuals are more concerned; Dr. Kuzel thinks individuals believe that EHR won't make much difference for them. Entering patient information from charts is a concern for doctors who have huge numbers of charts. He referred to EHR as the inevitable and said that it is being required in residency programs. He said there is improved documentation and better flow to pharmacies in terms of better prescription refills associated with electronic systems. Recent paper in Annals of Family Medicine that looked at those that had EHR and those that didn't. Those that did have it ordered more hemoglobin Cs and more LDLs, but both those that did have EHR and those that did not showed improvement in chronic disease management.

Cost of implementing EHR per doc basis is roughly $10,000 to $20,000, according to Kuzel. He said having someone on hand to do the business analysis to help ensure the ROI is happening in some places and is helpful. He said that, in the way of who can benefit, insurance companies could benefit from unnecessary retesting. Multiple partners in a community or in a state can be brought together to play a role….

Dave asked how data is being put into these electronic health record systems. Kuzel said some doctors are cutting down patient load by 20% to do the data entry at or before the time of a visit. He also said that by 3 months in, most doctors are back up to their normal pace.

Impact of EHR on a Private Practice (C-Health??)
Hughes Melton, MD

This is an example of a medical practice that started using EHRs right from the start—they never had a paper system.

- He said that, nationally, physicians are going to have to go electronic over the next 8 to 10 years.

- Biggest advantage has been flexibility and the ability to capture the work that you are doing. E.g., when you look at past medical history, it's all right there. Most systems have a module that allows you to deal with health maintenance types of items, which helps remind doctors to do maintenance things that they might not get to.
- Question was asked: What about the reduction of productivity from having to deal with electronic stuff rather than paper stuff. Dr. Melton said he did not think that was inevitable. He said he can chart the stuff while the patient is still in the room. "Snippets of down time" let you get your documentation done, he says. He said 90% of the time he is done with the record at the time that he finishes the appointment, so it is not more time-consuming, necessarily. He said Health IT is template-driven, and that they tailor those effectively.
- Question was asked about interfacing: Starting in September, they'll have a fax interface that allows faxed information to be electronic. Soon they will get an interface with their main reference lab.
- It was asked if he is electronically prescribing medications. He said he does not hand-write them anymore and that the fax interface will allow them to send them to pharmacies when it's set up.
- Question was asked: Any electronic interaction with Virginia Department of Health agencies. He said billing is done electronically. It was asked how he communicates with public health facilities – if it's electronic. He said that they print out a health summary and fax things, but that there is not direct electronic communication.
- It was asked about emergency departments and his office – whether they communicate electronically. He said no.
- It was asked if the templates lend themselves to greater keying accuracy and better reimbursement rates as a result. He said yes. He said they're not at a whole level higher as a result, but maybe 60-70% of a level higher.
- It was asked if the electronic environment allows them to do more sophisticated analyses so that they can see more patients and do a better job. He said they can do data mining to find out things, like how many patients have had mammograms, how many are diabetic, etc. The documentation is more efficient when patients call in. He said things get documented more completely because of the ease of getting to the "chart" – e.g., using the computer.
- It was asked if not having to search for paper charts translates into a revenue savings. Better coding and reduced denials are two immediate economic advantages. Being able to bill for all the work you have done is another benefit, as is being done with your work at the end of the day – e.g., no dictating for an hour or whatever. Also, it's quicker to go through a couple of computer screens than use paper. Not having to have a staff member to pull charts, nor needing the space to store them, also helps. Just the E&M difference pays for the expense of the system, according to Dr. Melton.
- It was asked – whether or not theyhave gotten any grief for trying to use electronic signatures. He said no, with respect to HCFA 1500s. It was asked if Medicaid or Medicare had ever come in and done an audit – if everything was OK with the e-signatures in that case. Dr. Melton said yes. A note cannot be changed

once it has been electronically signed. An addendum can be added, but it cannot be changed. Billing for the correct "chief complaint" has to be done. If medical attention was given for something NOT on the chief complaint line, then that may not end up being reimbursed – that kind of thing. It was suggested that some of the things we are trying to do with EHR may run counter to billing and reimbursement practices.

Challenges and Advantages of using EHR in a Large Private Medical Practice—Northern Virginia

James Lapsley, CEO of Loudoun Medical Group

Loudoun Medical Group (LMG) is multi-specialty, multi-physician owned facility. It has a very broad range of specialties with 150 providers including physicians, nurse practitioners, nurses. They have 51 locations and see about 500,000 patients annually. Company was formed in 2000. They do specialty and primary care.

They only recently decided to invest in EHR, and it is for them a $4 million investment. The hardware and implementation account for over 60 percent of the cost (The main cost is NOT the software.)_

Their main desire was to get rid of all of the paper. Also, they're in a high-tech area, so the consumers there have an interest in the electronic aspect. Patients have communicated electronically with physicians and done medical research on the internet and have made requests about EHRs.

LMG's interests were: elimination of variance of providing care, elimination of duplication of care, quality assurance, testing, compliance with documentation guidelines, etc. Also interest in what's being referred to as "wrap around" services where physicians in different specialties come together and implement a community medical record. If the community medical records can get prospective review to negotiate with preferred managed care contract rates, that would be good.

LMG had a two-year review process of hundreds of electronic medical records. They selected AllScrips. A key factor was physician buy-in. Had a lot of steering committees that lent themselves to buy-in on the part of the physicians, which he identifies as key to successful implementation.

They see it as a cost to the organization and will be pleasantly surprised if it adds benefit to their bottom line. He said Quality Assurance, variance of healthcare, and reduction of duplication are still very good reasons to do it, as is the elimination of pushing paper.

LMG did a lot to investigate the quality of the vendor as the area of electronic meddical records evolves. Because they are a big physician practice, the had the resources to

conduct thorough cost analyses, research into different systems, and even requests for proposals. The wanted modular, scaleable systemthtat was easy to use .

They are just starting the implementation. Fairfax residency program is live with it. They see it as an 18-month to two-year process.

A question was asked about what they do with old medical records: They scan the whole record to avoid having to reach a consensus about which parts of the record could be omitted. They will have all interfaces (e.g., with reference labs, hospitals they use, most of radiology companies, billing system) soon. Interfaces should not be underestimated in the value they bring, but also the cost they bring. Interface with one of their reference labs was $30,000 by itself.

Challenges – Some are industry-wide, some specific to Loudoun Medical Group. Every implementation will be different. Implementations will vary based on age of providers and type of specialty. Older physicians may be less comfortable with technology, for example. The functionality of the electronic medical record is still evolving. What are the differences in legal requirements for paper versus electronic? Lapsley indicated that this is an issue and that in many of the areas there is no case law on the subject just yet. The industry is evolving…He said that concerns them for other doctors who are not as well-equipped with resources.

Vendors making promises is an issue. Will vendors deliver to the small practices as they say they will? Again, cost of software is the smallest component. It's the hardware, implementation, and maintenance that are costly. It was asked if the $4M was just the initial cost. Lapsley said it would cover hardware, software, implementation, and the first year of "ongoing costs". He said well over 60% of their $4M is implementation and hardware.

A question was asked about whether the system has structured templates or whether the physicians just use unstructured notes. LMG will be using templates but can do unstructured notes as well. The templates also provide the information in letter form.

Potential Pilot Program Discussion

One subcommittee member said they are proposing a behavioral health RHIO that would allow different groups in the behavioral health setting where their data is shared across that network. . He suggested that this will be a different way of looking at electronic medical records, in that the data would be in a repository instead of in an individual record. Key is the ability to exchange data points among organizations.

It was asked if there are other behavioral health organizations that have submitted proposals for funding.

Outline of Subcommittee #2 Report to the Full Task Force

Staff will be sending out an outline or draft of the subcommittee report based on a template that the secretary's office has signed off on.

Format is roughly as follows for the first cut of the report:

- Executive summary and introduction
- Vision Statement
- Executive Directive from Governor (collaboration of stakeholders, etc.)
- Recommended actions (e.g., what the state can do with the "bully pulpit"; what the state can do as a payer; how the state can create infrastructure; other areas like what can be done to eliminate barriers to electronic health record implementation)
- Background
- Members of current subcommittee

Staff said the above will be sent to committee members by Friday. September 2, and requested that comments be sent back by Friday, September 9.

The next Subcommittee #2 Teleconference is scheduled for September 19th. Staff indicated that it was open to suggestions about scheduling of meetings after September 19.